Testimony of

Gary Wirth, RPh, MBA
Director of Professional Services
Ahold USA

On

Examining the Federal Government's Partnership with America's Pharmacists

To

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Good afternoon Chairman Deal, Ranking Member Brown, and Members of the Energy & Commerce Health Subcommittee. I am Gary Wirth, Director of Professional Services at Ahold USA. I am pleased and honored to be here today to participate in this important hearing.

Ahold USA, owned by Ahold of the Netherlands, currently operates four prominent supermarket companies along the eastern seaboard including The Stop & Shop Supermarket Company, headquartered in Boston, MA; Giant Food LLC, based in Landover, MD; Giant Food Stores LLC, based in Carlisle, PA and Tops Markets LLC, with headquarters in Buffalo, NY. Jointly they operate over 1,100 supermarkets with 670 pharmacies, and employ over 122,000 associates. Ahold (NYSE: AHO) is a leading food provider in the United States and elsewhere in the world with 2004 consolidated net sales of approximately USD 50 billion.

Ahold USA commends you on holding this hearing to examine the federal government's partnership with America's pharmacists. Indeed, this is a critical time for pharmacists and community pharmacy. We face greater demand for our services as a result of factors such as the aging of the population and increased prescription drug volume. Simultaneously, our industry is challenged by increasing competition within community pharmacy as well as from both legitimate mail order facilities and illegal prescription drug importation and Internet pharmacies. Furthermore, there is continued pressure from both public and private payers to lower reimbursement.

As the community pharmacy industry continues to evolve in response to these changing market forces, we also recognize our relationship with the federal government is paramount. In addition to its role as our largest payer, the federal government is also the architect of public programs and policy changes that dramatically effect community pharmacy. I'd like to spend the majority of my time before you today discussing the current status of one of these bold policy initiatives, the Medicare Part D prescription drug benefit.

Ahold USA is proud to have played a key role in assuring that millions of additional seniors now have access to prescription drug coverage as a result of the Part D benefit. As we all know, there were significant problems in the early days of the program, most of which stemmed from technological and data integrity failures. Fortunately, while there are ongoing challenges, many of these issues from the early days of implementation have stabilized.

There was a striking consistency in many of the reports about the early difficulties of the Part D benefit – the unique role of pharmacists and their efforts to serve Medicare beneficiaries. The Part D rollout was a strong reminder of community pharmacists' unique position as one of the most accessible and trusted health care providers, and the importance of a strong and vital retail community pharmacy infrastructure to our nation.

As I mentioned, many of the early issues with the Part D benefit have been resolved. However, there are ongoing issues that we think can be corrected to continue to ease the

administrative burdens placed on pharmacists and to facilitate beneficiary access to their medications. Ahold USA has several suggestions on how some of the ongoing implementation issues can be addressed:

Fix Enrollment Lag: Individuals become eligible for Medicare every day, and dual eligibles have the option of changing plans every month. As a result, there is a systematic issue, commonly referred to as the "enrollment lag," that is problematic for pharmacies and beneficiaries.

Currently, a Medicare beneficiary can enroll in a Part D plan at any time and expect their enrollment to be effective the first day of the following month. If a beneficiary applies for the Part D benefit in the last few days of the month, it is simply not possible for CMS and health plans to process the beneficiary's application, confirm eligibility with CMS, and provide the necessary billing information so that it is available to pharmacists in time for the beneficiary to receive their prescriptions the first day of the next month.

Unless policymakers address this "enrollment lag" issue, late-month enrollment or plan switches may continue to be the single most challenging issue that beneficiaries and pharmacists face with Part D. If pharmacists don't have the necessary data, they cannot fill a prescription. This takes pharmacists away from serving their patients, and forces a series of calls to CMS and health plans to obtain billing and enrollment information. Pharmacists and other pharmacy staff find this experience very frustrating, but even more importantly, so do Medicare beneficiaries, who are forced to wait for extended periods of time at the pharmacy or return at a later date to obtain their prescriptions.

A variety of options exist to address this issue, and Ahold USA and the chain drug industry are committed to working with CMS and health plans to find the best solution. CMS is trying to address this issue by educating beneficiaries that enrolling late in the month will result in delays in activation of prescription drug coverage. This is a step in the right direction. Optimally, there should be an enrollment deadline established each month so there is sufficient time to process applications and enter the billing information in the system. We urge policymakers to address this issue.

Improve and Reward Quality: Ahold USA welcomes the recent announcement by CMS Administrator Mark McClellan on the formation of the Pharmacy Quality Alliance (PQA), a collaborative effort among the pharmacy community, health plans, employers, government payers, and others to improve health care quality. We believe initiatives like PQA are an ideal way to further strengthen the partnership between the federal government and pharmacists. Identifying tools that result in better health outcomes and reduce health care costs for payers benefit pharmacists, the government, and patients.

In addition to developing strategies to define and measure pharmacy performance, CMS has indicated that PQA could also lead to new pharmacy payment models based on optimizing patient outcomes. Ahold USA supports efforts that focus on controlling costs by paying for better care and improved outcomes, and not by reducing payment rates to providers.

Level Playing Field: Community pharmacy is a highly efficient, competitive industry, operating on an average profit margin of 2 percent. Traditional chain pharmacies, supermarkets and mass merchants with pharmacies, and independent pharmacies use service, convenience, pricing, and other factors to compete aggressively. In recent years, mail order pharmacies have also become an increasing source of competition for community pharmacy. Confident of our patients' preference for their local pharmacy and the service it provides, we are certain of our ability to compete with mail order. Our request to policymakers when considering the use of mail order in public programs such as Medicare has always been to ensure a level playing field with community pharmacy.

In private sector contracts, pharmacy benefit managers (PBMs) often restrict the use of retail pharmacies in order to drive beneficiaries to use their mail order facilities. For example, typical contracts prohibit retail pharmacies from dispensing extended days supply (i.e. 90-day supplies) of medication, and require these maintenance supplies of drugs to be obtained via the PBMs' mail order pharmacy.

Recognizing the importance of patient choice and the value of the community pharmacist, the Medicare Modernization Act (MMA) attempted to limit this steering. Largely as a result of the efforts of many Members of this Subcommittee and broad congressional support, MMA was very clear that retail pharmacies could fill extended day supplies of prescription drugs as long as they agreed to the same level of payment as a mail order pharmacy. This provision, while not ideal for local pharmacies, at least offered them the opportunity to continue to dispense these prescriptions.

Unfortunately, CMS' current interpretation of this provision, as well as tactics being used by Part D plans, are inconsistent with congressional intent. Seniors are being denied the choice of obtaining these prescriptions at community retail pharmacies.

For example, some plans are telling pharmacies that they can only provide extended days supply under Medicare Part D if they accept this mail order rate for the plan's non-Medicare commercial business. Other PDPs will only allow a retail pharmacy to offer an extended days supply if the pharmacy agrees to accept the mail order reimbursement rate for all claims that are submitted, for both short term prescription quantities and extended days supply quantities.

Schemes such as these make it more difficult for retail pharmacies to offer an extended days supply, and deny the beneficiary the choice between retail and mail. We also believe that they are inconsistent with the intent of Congress.

Formulary Issues: There have been some difficulties for both beneficiaries and pharmacists with understanding Part D drug formularies and how they work. Many beneficiaries that come into our pharmacies are concerned that in the future a plan could remove the drugs they are taking from the Part D plan's formulary. Our pharmacists are also concerned about the quality of care impact of switching beneficiaries from a medication they have been taking for a long time to a different medication. There are also

concerns about whether beneficiaries – especially low income dual eligibles – will be able to navigate the exceptions and appeals process. That is why we think that CMS' recent decision to allow a beneficiary to continue taking a formulary medication – even if the plan changes the formulary – is good for quality health care and will reduce the administrative burdens on beneficiaries, physicians and pharmacists to switch medications for Medicare beneficiaries.

Coverage Gaps: We are rapidly approaching the middle of the year when many seniors may fall into the "donut hole" or coverage gap. We are concerned that many Medicare beneficiaries do not fully understand the issues relating to the "donut hole" and how it will affect their Medicare coverage. Many of our pharmacists are concerned they will bear the brunt of beneficiary frustrations when they find out they are still paying premiums while in the "donut hole," but not receiving any coverage for their prescription medications.

We believe another public-private sector collaboration to develop assistance programs for beneficiaries when they hit the coverage gap would go a long way toward improvement of the program. Community pharmacy is held to charging the beneficiary no more than their discounted contract rate and therefore contributes directly to assisting beneficiaries in the coverage gap. However, many beneficiaries will undoubtedly need additional assistance to assure their access to needed medications, so we believe other parts of the system should step forward and do their part as well.

While the focus of my testimony has been on Medicare, I would like to address another critical component of the federal government's partnership with pharmacists – the Medicaid program.

While Ahold USA and other pharmacies across the country are still making adjustments as a result of Part D, we will again be asked to shoulder an incredible burden only one year later when drastic changes to the Medicaid program are implemented. We are very concerned with the changes to the Medicaid program as part of the Deficit Reduction Act (DRA), which will dramatically impact community pharmacy's ability to serve Medicaid patients.

Community pharmacy worked closely with this Subcommittee on the Medicaid provisions of the DRA. We were supportive of the Subcommittee's goal to pay pharmacies fairly and accurately for both the prescription drug product, and the professional services associated with dispensing. Recognizing these two, discrete components of pharmacy reimbursement, the House version of the Deficit Reduction Act included a minimum dispensing fee of $8 for generic drug prescriptions. This provision recognized the importance of reimbursing pharmacy for the costs associated with dispensing prescription drugs, and also attempted to maintain an incentive for dispensing generic medications. Unfortunately, the minimum dispensing fee for generic drugs was not included in the conference report. The loss of this important provision makes the DRA's dramatic reductions to product reimbursement event more devastating for community pharmacy.

The DRA reduces payments to pharmacies for generic medications by about $6.3 billion over the next four years. Beginning January 1, 2007, federal upper limits (FUL) for generic drugs will be based on Average Manufacturers Price (AMP), rather than Average Wholesale Price (AWP). We believe that the reduction in payment will be so severe that it will take away much of the incentive for pharmacists to dispense generic medications. This is counterproductive, given that less than 25 percent of the average state's Medicaid pharmacy payments are for generics, even though generics account for more than 50 percent of prescription volume. Public and private payers should be doing everything they can to increase, not decrease, the dispensing of generic drugs, since generic drug utilization is one of the most effective ways to control prescription drug costs.

The Deficit Reduction Act also requires CMS to make Average Manufacturers Price data available to states and the public soon. In theory, AMP is supposed to reflect the average prices paid to manufacturers by wholesalers for drugs distributed to the retail class of trade, which include retail pharmacies. However, we are very concerned that since there are no guidelines as to how manufacturers should calculate AMP, the AMP data released by CMS will be inaccurate and will not reflect the actual prices that retail pharmacy pays for brand and generic medications. As a result, states, Medicare plans, and consumers could receive a misleading picture about the true acquisition costs of retail pharmacies. Medicare plans and other payers could conceivably change their pharmacy reimbursement based on faulty AMP data.

This data will be publicly available before CMS is required to issue a rule instructing drug manufacturers on how to calculate AMP. Because of its potential damaging impact to community pharmacy, we believe that this data should not be made public or shared with the states until AMP is accurately and consistently defined.

Reductions of this magnitude in Medicaid, coupled with the current economic impact of the Medicare Part D program, will unquestionably reduce access to pharmacies. We do not believe that policymakers have taken into account the cumulative economic impact that changes to Medicare and Medicaid will have on retail pharmacies and the communities they serve. We hope that you will continue to partner with America's pharmacists and pharmacies in developing public policy that benefits patients, payers, and pharmacies.

Thank you again for this opportunity to share Ahold USA's perspective. We look forward to continuing to work with Congress and the Administration on these issues. I would be happy to answer any questions. Thank you.